Thank you for your interest in the Service Benefit Plan.
We’re committed to helping you live life to the fullest.
Thank you for taking the time to learn more about the Blue Cross and Blue Shield (BCBS) Service Benefit Plan. For over 50 years, we’ve worked with the Office of Personnel Management to bring you our Plan.

We want to support you in your day-to-day life, not just when you visit the doctor. That’s why we’re offering our members new programs and technology, such as fitness device integration, so that you earn wellness rewards for the everyday things you are already doing.

Here’s a brief look at some other things you can look forward to in 2016:

**Increased Wellness Incentives**: You’ll earn $50 when you complete the Blue Health Assessment and up to an additional $120 when you complete three goals with the Online Health Coach. In total, you can earn $170—that’s double the incentive rewards you could earn in 2015.

**Pregnancy Care Incentive Program**: We’re introducing the Pregnancy Care Incentive Program in 2016, which offers expectant mothers a Pregnancy Care Box with items to support them throughout their pregnancy and $75 on their MyBlue® Wellness Card.

**Hypertension Management Program**: We’re taking a stand against heart attacks and strokes by helping our members manage high blood pressure with our Hypertension Management Program. Eligible members can request to receive a blood pressure monitor to help them monitor their blood pressure.

Continue reading through this booklet to learn more about us and what we offer. If you have additional questions after reading through this material, feel free to visit our website www.fepblue.org for more information.

If you would like to speak to someone on the phone, please call our Open Season Information Center at 1-800-411-BLUE (2583), weekdays from 8 a.m to 8 p.m. The Center opens on November 2, 2015. You can request additional information when you speak to one of our representatives.

Thank you again for considering the Service Benefit Plan. We’re excited to partner with federal employees, retirees and their families in 2016.

Continue to live life well,

The Blue Cross and Blue Shield Service Benefit Plan

BlueCross
BlueShield
Federal Employee Program.
WHAT’S NEW FOR 2016
Updates and changes to our Plan

Enrollment types
Starting in 2016, the federal government will offer a new enrollment type, Self Plus One, in addition to the two other enrollment types: Self Only and Self and Family.

The new Self Plus One enrollment codes are:

- Standard Option Self Plus One: 106
- Basic Option Self Plus One: 113

Self Plus One covers you and one eligible dependent, such as a spouse or a child under 26. You receive the same benefits and overall value no matter which enrollment type you choose.

If you would like to enroll in Self Plus One, you must make this change during Open Season. Contact the agency or Tribal Employer that maintains your health insurance coverage for more information.

You can visit www.fepblue.org/enrollment for more information on our enrollment types.

Wellness incentives
• We’ve increased the amount you can earn when you complete eligible goals with the Online Health Coach to $40 for each goal up to three—for a total of $120. See page 10 of this booklet for more information.

• Expectant mothers can participate in the new Pregnancy Care Incentive Program and receive a Pregnancy Care Box and $75 in wellness incentives when they complete the program requirements. See page 11 for more information.

• Members with high blood pressure can participate in the Hypertension Management Program and receive a free blood pressure monitor when they complete the BHA and indicate they have high blood pressure. See page 12 for more information.

Preventive benefits
• Pregnant members can receive low-dose aspirin to prevent preeclampsia when they order the drug from a Preferred retail pharmacy or through the Mail Service Pharmacy Program.

• Members age 13 and older can receive one preventive hepatitis B screening per calendar year.

• Children up to age 5 are eligible for a fluoride varnish application by a primary care provider. Limited to two per calendar year.

• Members age 65-75 can receive one preventive ultrasound for aortic abdominal aneurysm per lifetime.

• We cover testing for large genomic rearrangements in the BRCA1 and BRCA2 genes, once per lifetime, for members 18 or older when they meet the criteria for preventive BRCA.

• We provide one osteoporosis screening per calendar year for all women 65 and older and women 50 to 65 at increased risk for osteoporosis.

• We provide allergy care and prescription drug benefits for specific FDA-approved allergy desensitization drugs.

Dental benefits
• We changed Standard Option dental benefits to only include coverage for evaluations, diagnostic imaging, palliative treatment and preventive care.

• We increased the copay for dental care services for Basic Option members to $30.
Physician and facility services

- We changed our coverage for observation care in a hospital setting.
- We increased the copay to visit a Preferred primary care physician to $25 for Standard Option and $30 for Basic Option.
- We increased the copay for specialty care providers to $35 for Standard Option and $40 for Basic Option.
- We increased the copay for inpatient hospital care and continuous home hospice care at a Preferred facility for Standard Option members to $350 per admission or episode.
- We have changed our criteria for coverage of inpatient care provided by a residential treatment center.
- We’ve reduced the cost of outpatient laparoscopic gastric stapling procedures when members visit a Blue Distinction Center for Bariatric Surgery®.
- We no longer require members to receive prior approval for intensity modulated radiation therapy (IMRT) services for the treatment of anal cancer.

Out-of-pocket maximum

- **Standard Option**: The out-of-pocket maximum for Preferred providers is $5,000 for Self Only contracts and $10,000 for Self Plus One and Self and Family contracts. For Non-preferred providers, the Self Only maximum is $7,000 and the Self Plus One and Self and Family maximum is $14,000.
- **Basic Option**: The out-of-pocket maximum is $5,500 for Self Only contracts and $11,000 for Self Plus One and Self and Family contracts.

For both Basic and Standard Option Self Plus One and Self and Family enrollments, once an individual on the contract reaches the Self Only out-of-pocket maximum, the maximum is met for that individual for the remainder of the calendar year.

Pharmacy benefits

- Basic Option members with Medicare Part B primary can now order prescription drugs through the Mail Service Pharmacy.
- Basic Option members now have a managed drug formulary instead of an open drug formulary.
- We’ve increased the cost share for drugs in Tiers 2 through 5 for Basic Option members without Medicare Part B primary.
- We provide prescription drug benefits for drugs used in the treatment of gender identity/gender dysphoria.
HELPING YOU LIVE LIFE TO THE FULLEST

Choose the option that’s best for you

We offer two coverage types, Standard Option and Basic Option, which offer you the service and coverage you expect from Blue Cross and Blue Shield. Both offer members great features, such as:

- A member ID card accepted in the U.S. and worldwide.
- No requirement to receive a referral for covered services.
- Free preventive care when performed by Preferred providers.
- Health and wellness programs, incentives and discounts offered at no additional cost to you.

However, each coverage type is unique in its offerings as well.

### Standard Option

If you choose Standard Option, you’ve opened the door to expanded coverage. Nationwide, 92% of professional providers and 96% of hospitals participate in our Preferred network. Visiting a Preferred provider means you’ll have lower out-of-pocket costs, and you won’t have to file a claim for covered services. However, if you choose, you can visit a provider outside of our network, and we’ll still pay a portion of the costs.

### Basic Option

Basic Option members also have access to our large network of Preferred providers; however, you must use these providers for all of your care, except in certain situations, like emergencies. If you choose to go out-of-network, you are responsible for all charges for the services.

### AskBlue®

If you need additional help deciding which option is the best for you, use our tool AskBlue for Federal Employees. AskBlue will ask you simple questions to understand your healthcare needs. It will then walk you through which option and enrollment type fits you and your family.

Visit askblue.fepblue.org to use the tool today.
### 2016 COMPARISON OF BENEFITS

#### WHAT YOU PAY WHEN YOU USE PREFERRED PROVIDERS

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>Standard Option</th>
<th>Basic Option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WELLNESS INCENTIVE PROGRAM</strong></td>
<td></td>
<td>Earn $50 for completing the Blue Health Assessment and up to $120 for achieving up to three eligible Online Health Coach goals. Learn more at <a href="http://www.fepblue.org">www.fepblue.org</a>.</td>
</tr>
<tr>
<td><strong>PREVENTIVE CARE</strong></td>
<td>You pay nothing</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>PHYSICIAN CARE</strong></td>
<td>$25 per visit copayment for primary care providers</td>
<td></td>
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<tr>
<td></td>
<td>$35 per visit copayment for specialists</td>
<td></td>
</tr>
<tr>
<td><strong>LAB, X-RAY &amp; OTHER DIAGNOSTIC SERVICES</strong></td>
<td>15%* of the Plan allowance</td>
<td></td>
</tr>
<tr>
<td><strong>HOSPITAL CARE</strong></td>
<td>Inpatient: $350 per admission</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outpatient: 15%* of the Plan allowance</td>
<td></td>
</tr>
<tr>
<td><strong>SURGICAL SERVICES</strong></td>
<td>15%* of the Plan allowance</td>
<td></td>
</tr>
<tr>
<td><strong>MATERNITY CARE</strong></td>
<td>Inpatient/Outpatient Hospital Care (Precertification is not required for normal delivery):</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No out-of-pocket expenses for covered services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician care including delivery and pre- and postnatal care: No out-of-pocket expenses for covered services</td>
<td></td>
</tr>
<tr>
<td><strong>URGENT CARE</strong></td>
<td>$30 copayment for urgent care center</td>
<td></td>
</tr>
<tr>
<td><strong>EMERGENCY CARE</strong></td>
<td>Accidental Injury: Nothing for outpatient, hospital and physician services within 72 hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical Emergency: Regular benefits for physician and hospital care*</td>
<td></td>
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<tr>
<td><strong>PRESCRIPTION DRUGS</strong></td>
<td>Preferred Retail Pharmacy:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 1 (Generic): 20% of the Plan allowance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 2 (Preferred brand name): 30% of the Plan allowance</td>
<td></td>
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<tr>
<td></td>
<td>Tier 3 (Non-preferred brand name): 45% of the Plan allowance</td>
<td></td>
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<tr>
<td></td>
<td>Mail Service Pharmacy:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 1 (Generic): $15 copayment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 2 (Preferred brand name): $80 copayment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3 (Non-preferred brand name): $105 copayment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty Pharmacy: Please see pages 8–9 for information on the Specialty Pharmacy Program.</td>
<td></td>
</tr>
<tr>
<td><strong>CHIROPRACTIC/OSTEOPATHIC MANIPULATIVE TREATMENT</strong></td>
<td>$25 copayment per visit; up to a combined 12 manipulations per year</td>
<td>$30 copayment per visit; up to a combined 20 manipulations per year</td>
</tr>
<tr>
<td><strong>DENTAL CARE</strong></td>
<td>The difference between the fee schedule amount and the Maximum Allowable Charge (MAC)</td>
<td>$30 copayment per evaluation; up to 2 per calendar year Preventive care only</td>
</tr>
<tr>
<td><strong>OUT-OF-POCKET MAXIMUM</strong></td>
<td>Preferred provider services: Your out-of-pocket maximum is $5,000 for Self Only and $10,000 for Self + One and Self &amp; Family contracts</td>
<td>Preferred provider services: Your out-of-pocket maximum is $5,500 for Self Only and $11,000 for Self + One and Self &amp; Family contracts</td>
</tr>
</tbody>
</table>

* Is subject to the 2016 Standard Option calendar year deductible: $350 per person or $700 per family. No deductible for 2016 Basic Option. If you use a Non-preferred physician or other healthcare professional under Standard Option, you generally pay any difference between our allowance and the billed amount, in addition to any share of our allowance shown in the table above. Basic Option generally does not provide benefits when you use Non-preferred providers. Certain deductibles, copayments and coinsurance amounts do not apply if Medicare is your primary coverage for medical services (it pays first).
Our network

We are a Preferred Provider Organization (PPO), which means that we have a network of providers who agree to accept our allowance as payment in full for their services. We call these healthcare professionals and facilities our “Preferred providers.” Visiting a Preferred provider means savings for you.

As a Service Benefit Plan member, you receive access to all the Preferred providers in our network—that’s almost 1 million providers you can choose from across the U.S. You can find a Preferred provider near you by visiting our online provider directory at www.fepblue.org/provider.

Receiving services

When you visit a Preferred provider and receive services, the provider submits your claim to us, and we pay based on our agreed upon allowance. You’ll then receive your Explanation of Benefits (EOB) which outlines any costs you are required to pay based on your benefits outlined in the 2016 Blue Cross and Blue Shield Service Benefit Plan brochure.

For some services like certain hospital stays, you will need to receive approval for the service before you receive benefits. This is called precertification or prior approval. In most cases, your doctor or the facility where you plan to receive the service will contact us about approval.

To find out what services require approval before you receive benefits, and to learn more about how to submit an approval request, see section 3 of the Service Benefit Plan brochure.
Out-of-network services

If you visit a Non-preferred provider for covered services and have Standard Option, we will still pay for a portion of the cost; however, your total out-of-pocket costs could be significantly higher than if you use a Preferred provider. You may also have to file your claim with us, rather than your provider filing it for you.

If you have Basic Option, you don’t receive out-of-network benefits, except in certain situations.

Your rights as a member of our Plan

All members of our Plan have certain rights and responsibilities—including the right to request more information from us or the providers in our network. To see a full list of our member rights, visit www.fepblue.org/memberrights.

Our privacy practices

We take the safety and security of your health information very seriously. All of our systems, including our online resources, operate in accordance with federal privacy laws.

We keep your medical records and claims information private and only disclose this information when necessary.

Each year we review our Notice of Privacy Practices. We send this Notice to all members when they first enroll. We also post the Notice to our website, so you can access it at any time. To view our current Notice of Privacy Practices, visit www.fepblue.org/privacynotice.
Mail Service Pharmacy Program
We offer the Mail Service Pharmacy Program to all our Standard Option members and to Basic Option members with Medicare Part B primary.

Here’s how you can order your drugs if you’re eligible:

1. Ask your doctor to prescribe a 22-day to 90-day supply of your drug plus any refills for up to a year.

2. Fill out and send the Mail Service Prescription Drug Order Form with your original prescription and your drug’s copayment amount. The form is available on www.fepblue.org or by calling 1-800-262-7890. Your doctor can also order the prescription for you directly by dialing the same number.

3. When you’re ready to order refills, you can order them online at www.fepblue.org/myblue or by phone at 1-877-337-3455. You’ll need the refill slip included with your previous prescription fill.

It’s that easy. All drugs ordered through the Program are sent via standard U.S. mail within two weeks, unless they require overnight shipping.

Retail Pharmacy Program
Through our partnership with CVS/caremark, our members have access to over 65,000 Preferred retail pharmacies nationwide. Using a Preferred retail pharmacy means that you’ll save money and you won’t have to file a claim for your drug.

If you have questions about the Retail Pharmacy Program or want to locate a pharmacy near you, call 1-800-624-5060 at any time to speak to a customer care representative. You can also visit www.fepblue.org/provider to find a local Preferred retail pharmacy online.

Specialty Pharmacy Program
Specialty drugs are used to treat complex health conditions and are usually high in cost. They have one or more of these features:

• Injectable, infused or inhaled.
• Products of biotechnology.
• Require special handling, shipping and storage
• Involve specialized patient training and coordination of care.

We have two drug tiers for specialty drugs: Tier 4 (Preferred) and Tier 5 (Non-preferred). We limit the supply of specialty drugs you can fill at one time, as well as where you can refill your specialty drugs. Please call 1-888-346-3731 if you have questions about the Specialty Pharmacy Program. Customer care representatives are available weekdays from 7 a.m. – 9 p.m. Eastern time and 8 a.m. – 6:30 p.m. Eastern time, Saturday and Sunday.

KNOW YOUR DRUG COST BEFORE YOU VISIT THE PHARMACY.
If you want to know what your out-of-pocket costs would be for your current prescriptions under Standard or Basic Option, you can use our Drug Treatment Cost Estimator at www.fepblue.org/pharmacy.
## 2016 Comparison of Pharmacy Benefits

### What You Pay When You Use Preferred Providers

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Standard Option</th>
<th>Basic Option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mail Service Pharmacy Program</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1 (Generics)*</td>
<td>$15 copayment</td>
<td>Available to members with Medicare Part B primary only:</td>
</tr>
<tr>
<td>Tier 2 (Preferred brand name)</td>
<td>$80 copayment</td>
<td>Tier 1 (Generics): $20 copayment</td>
</tr>
<tr>
<td>Tier 3 (Non-preferred brand name)</td>
<td>$105 copayment</td>
<td>Tier 2 (Preferred brand name): $90 copayment</td>
</tr>
<tr>
<td></td>
<td>Covers 22 to 90-day supply</td>
<td>Tier 3 (Non-preferred brand name): $115 copayment</td>
</tr>
<tr>
<td><strong>Retail Pharmacy Program</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1 (Generics)*</td>
<td>20% of the Plan allowance</td>
<td>Tier 1 (Generics): $10 copayment</td>
</tr>
<tr>
<td>Tier 2 (Preferred brand name)</td>
<td>30% of the Plan allowance</td>
<td>Tier 2 (Preferred brand name)*: $50 copayment</td>
</tr>
<tr>
<td>Tier 3 (Non-preferred brand name)</td>
<td>45% of the Plan allowance</td>
<td>Tier 3 (Non-preferred brand name)*: 60% of the Plan allowance ($65 minimum)</td>
</tr>
<tr>
<td></td>
<td>Covers up to a 90-day supply</td>
<td>Covers a 30-day supply, up to 90-day supply for additional copayments</td>
</tr>
<tr>
<td>Tier 4 (Preferred specialty)</td>
<td>30% of the Plan allowance (30-day supply)</td>
<td>Tier 4 (Preferred specialty)*: $65 copayment (30-day supply)</td>
</tr>
<tr>
<td>Tier 5 (Non-preferred specialty)</td>
<td>30% of the Plan allowance (30-day supply)</td>
<td>Tier 5 (Non-preferred specialty)*: $90 copayment (30-day supply)</td>
</tr>
<tr>
<td></td>
<td>Tier 4 and 5 specialty drugs are limited to a 30-day supply; one fill allowed.</td>
<td>All refills must be obtained from the Specialty Pharmacy Program.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialty Pharmacy Program</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 4 (Preferred specialty)</td>
<td>$35 copayment (30-day supply); $95 copayment (31 to 90-day supply)</td>
<td>Tier 4 (Preferred specialty)*: $55 copayment (30-day supply); $165 copayment (31 to 90-day supply)</td>
</tr>
<tr>
<td>Tier 5 (Non-preferred specialty)</td>
<td>$55 copayment (30-day supply); $155 copayment (31 to 90-day supply)</td>
<td>Tier 5 (Non-preferred specialty)*: $80 copayment (30-day supply); $240 copayment (31 to 90-day supply)</td>
</tr>
<tr>
<td></td>
<td>90-day supply can only be obtained after 3rd fill.</td>
<td></td>
</tr>
</tbody>
</table>

*Your costs for certain prescription drugs are lower if you have Medicare Part B primary coverage. Certain drugs require prior approval.
BETTER HEALTH AND OUR BEST REWARDS YET

Wellness Incentive Program

In 2016, we’re giving you more reasons to step up to better health—320 to be exact. That’s right, you can earn up to $320* just by taking steps to improve or maintain your health by going to www.fepblue.org/myblue to start the process.

- Earn $50 when you complete the Blue Health Assessment.
- Earn up to $120 when you complete three eligible Online Health Coach goals.
- Earn $75 with the Pregnancy Care Incentive Program.
- Earn $75 with the Diabetes Management Incentive Program.

That’s up to $320 to spend on qualified medical expenses—like new glasses, dental expenses or prescription costs. And, on top of wellness rewards, you’ll have the tools and resources you need to keep you at your best.

*Members receive incentive rewards on their MyBlue Wellness Card, which is a debit card that can be used to pay for qualified medical expenses. Up to two members on a contract, age 18 and over, can earn incentive rewards.

Blue Health Assessment –
Your $50 reward is just minutes away.

Begin by simply answering questions related to your health and receive a confidential, concise, personalized plan for a healthier you. You can take the Blue Health Assessment (BHA) multiple times throughout the year to update your plan and see your progress. Plus, you’ll earn $50 the first time you complete the BHA in 2016.

Once you complete the BHA, you’ll receive a personalized wellness plan and suggestions for realistic, personalized goals to help improve your health.

Online Health Coach –
Connecting you to a healthier, happier you.

We don’t just help you pay your healthcare bills; we do everything we can to help you stay well. That’s why this year, we’re making it even easier to stay on track by giving you $40 for each eligible Online Health Coach goal you complete up to three—that’s $120 in total.

The Online Health Coach is available at no cost to you to help you make healthy changes, such as reducing stress, exercising more, eating better, losing weight and feeling happier.

You can also get ideas and encouragement for managing your chronic conditions like heart disease, chronic obstructive pulmonary disease (COPD) or asthma. And, as always, your wellness activities and results are completely confidential.

SYNC YOUR FITNESS DEVICE:
If you have a Fitbit®, you can sync your device to MyBlue to help you reach your Online Health Coach goals. Your device also syncs to your Personal Health Record so you can easily share your progress with your doctor.

Learn more and get started today at www.fepblue.org/fit
Pregnancy Care Incentive Program

Our newest program helps pregnant mothers prepare for the newest addition to their family.

How it works

Once you complete the assessment, you may be eligible to earn $50 on your MyBlue Wellness Card.

2. Enroll in My Pregnancy Assistant on MyBlue.
When you register, we’ll send you a Pregnancy Care Box that’s filled with items, such as samples of wellness products you can use during your pregnancy to help you prepare for the arrival of your baby.

3. Visit your healthcare provider in the first trimester (first three months) of your pregnancy.
For both our Standard and Basic Option members, there’s no out-of-pocket cost for regular prenatal care visits.

4. Tell us about your first trimester visit by sharing your medical record.
Once you send us the pages on your medical record that show your prenatal visit, you’ll earn $75 on your MyBlue Wellness Card.

Additional benefits for expecting and new moms

You can receive one free breast pump kit per calendar year if you are pregnant and/or nursing. You have a choice of a manual or electric pump, and each kit includes a supply of milk storage bags. If you choose to buy your own breast pump, you can still receive a free supply of milk storage bags.

You can also receive breastfeeding education and individual coaching on breastfeeding from a healthcare professional at no additional charge to you. See the Service Benefit Plan brochure for more information.
GET THE MOST OUT OF YOUR COVERAGE

Receive additional support

Diabetes Management Incentive Program

If you have diabetes, receive the support you need to help you control your condition. If you complete the BHA and indicate that you have diabetes, you can participate in our Diabetes Management Incentive Program. Earn up to $75 in rewards by doing simple things to manage your diabetes, such as reporting your A1c levels or receiving an annual diabetic foot exam. Visit www.fepblue.org/diabetes to see a full list of eligible activities and for more information.

Tobacco Cessation Incentive Program

Win the fight against tobacco with the Tobacco Cessation Incentive Program. When you complete the BHA and create a Quit Plan with the Online Health Coach, you are eligible to receive prescription and/or over-the-counter (OTC) tobacco cessation products at no additional out-of-pocket cost to you when you visit a Preferred retail pharmacy.

Hypertension Management Program

Do you know your blood pressure numbers? Everyone should get their blood pressure checked by their doctor regularly. If your doctor says that you have high blood pressure or hypertension, take the BHA and indicate that you have high blood pressure. You then may be eligible to receive a blood pressure monitor at no out-of-pocket cost to you.

Your blood pressure monitor can help you check your numbers at home, so you can control your blood pressure. Doing so could possibly prevent a more serious condition like a heart attack or stroke later on. Make monitoring your numbers part of your hypertension management routine—just like taking your blood pressure medication and following a healthy diet.
Tools and resources built around your needs

Health club memberships*

We have a network of almost 10,000 health clubs nationwide that you can visit when you pay a $25 initial enrollment fee and then a $25 monthly fee. Once you’re enrolled, you can visit any of the fitness clubs as often as you want—you are not required to choose one specific facility. The network has many name brand and local facilities, so choose to visit the ones that fit you best.

You can enroll or find out more by visiting www.fepblue.org/healthclub or by calling 1-888-242-2060.

Blue365®

Blue365* offers you exclusive health and wellness deals, year-round. Discounts are available for programs related to financial health, fitness, nutrition, lifestyle, personal care and wellness. Visit www.fepblue.org/blue365 for more details.

WalkingWorks®

Walking just 30 minutes a day can be beneficial to your health. Join WalkingWorks, and you’ll receive a free pedometer and walking guide. Sign up today at www.fepblue.org/walking-works.

Local programs

Each of our local BCBS companies offer unique programs to our members, such as local care management programs that offer additional support to members with certain conditions.

Many BCBS companies also plan events or provide materials throughout the year to help you get the most out of your healthcare coverage.

Resources on MyBlue

MyBlue is our members’ only portal at www.fepblue.org/myblue. On MyBlue you’re in control of your healthcare.

- View current Explanation of Benefits (EOBs) and opt out of receiving paper copies.
- Keep track of your medical history with your Personal Health Record (PHR).
- Receive quarterly and annual snapshots of your claims with your Benefits Statements.
- Request a new member ID card.
- Update your address, phone number and/or email address.
- And much more.

CALL THE NURSE LINE

at 1-888-258-3432 if you need health advice. Nurses are available 24 hours a day, seven days a week. You can also chat or email a nurse online once you register for MyBlue.

*These benefits are neither offered or guaranteed under contract with the Federal Employees Health Benefits (FEHB) Program but are made available to all enrollees and family members who become members of the Service Benefit Plan.
THE CARD THAT TRAVELS WITH YOU
Benefits that go where you go

Your Service Benefit Plan member ID card does not just open doors in all 50 states—it opens doors worldwide. Whether you’re working overseas or taking a family vacation outside the U.S., you can receive the care you need, when you need it.

Strength in numbers
When you’re overseas, you can use any covered provider; however, we have an overseas network that has nearly 8,400 hospitals and over 12,000 professional providers.

To find an overseas provider online, visit www.fepblue.org/provider and click “Overseas Providers.”

We also have a dedicated Worldwide Assistance Center that you can call 24/7 when you’re outside the U.S. The Center can help you navigate to the closest provider or help you if you need assistance using your benefits overseas. Call the Center collect at 1-804-673-1678 or email a representative at fepoverseas@axa-assistance.us.

How we pay for physician and hospital care overseas
We pay for covered services performed overseas at the Preferred benefit level for both Standard and Basic Option. If you have Basic Option, you don’t have to use Preferred providers to receive care when you’re overseas.

Direct Billing: Some professional providers participate in a Direct Billing arrangement with AXA, our overseas vendor. This means that they will bill AXA, and they receive payment from them directly—no need for you to file a claim. In addition, these providers agree to accept our allowance as payment in full for their services, so you are only responsible for your usual out-of-pocket costs.

Overseas Fee Schedule: For all other professional providers, we pay using an Overseas Fee Schedule as our Plan allowance. If you visit one of these providers, you pay any deductibles, copayments or coinsurance amounts for your care. You also usually pay the difference between our allowance and the billed amount.

WE MAKE IT EASY FOR YOU TO USE YOUR BENEFITS OUTSIDE OF THE COUNTRY. YOU CAN:
• Get reimbursed for your claims in local currency or in U.S. dollars.
• Receive your payment by secure bank wire or as a check.
• Submit your claims by mail, fax or online.
• Receive emergency evacuation services to the nearest facility equipped to treat your condition.
• Access a provider within our large network.
How we pay for prescription drugs overseas

You still receive your pharmacy benefits when you’re outside the U.S.; however, when you buy drugs outside of the country, they must be the same as drugs that legally require a prescription in the U.S. All drugs purchased out of the country are provided at the in-network benefit level. You are responsible for paying the copayment amount—Standard Option members do not need to meet the calendar year deductible when purchasing drugs overseas.

Standard Option and Basic Option members with primary Medicare Part B coverage can purchase prescriptions using the Mail Service Pharmacy Program. To use this service overseas, your address must have a U.S. zip code (such as APO and FPO addresses), and the doctor who prescribed the medicine must have a National Provider Identifier (NPI) and be licensed in the U.S., Puerto Rico or the U.S. Virgin Islands. Delivery of the drug must also be permitted by law and be in accordance with the manufacturer’s guidelines.

File your claims conveniently

Providers that agree to a Direct Billing arrangement file your claims for you. For all other providers, you will have to submit your medical claims and all pharmacy claims for reimbursement. You can download claim forms at any time on www.fepblue.org, or you can call 1-888-999-9862 to request a form.

There are three easy ways to submit your claims forms and itemized bills: mail, fax or online submission. If you want to mail or fax your form, please see section 5(i) of the Service Benefit Plan brochure or visit www.fepblue.org for specific instructions.

To submit your claim form online, you can log in or register for MyBlue at www.fepblue.org/myblue. On the homepage, hover over the Health Tools tab and click “Submit Overseas Claim.” Then follow the instructions to submit the claim and upload your itemized bills.

Find out more

You can visit www.fepblue.org/overseas to learn more about your benefits overseas. You can also reference section 5(i) of the Service Benefit Plan brochure.
FLEXIBLE SPENDING BUILT AROUND YOUR NEEDS

Understanding FSAFEDS

FSAFEDS is the flexible spending account (FSA) program for federal employees. Think of it as a savings account that helps you pay for items that typically aren’t covered by the Service Benefit Plan, the Federal Employees Dental and Vision Insurance Program (FEDVIP) or other health insurance coverage. Copayments, prescriptions and dental/vision expenses are items you likely have to pay for out of pocket, and FSAFEDS helps you pay for those expenses.

FSAFEDS gives you a tax advantage on the funds you contribute to your account. You contribute to your FSAFEDS account via payroll deductions, and that money is never taxed. You pay less in taxes, which means more money in your pocket!

FSAFEDS offers a carryover option for healthcare and limited expense healthcare FSAs. If you are enrolled in one of these FSAs next year, you will be able to bring up to $500 of unspent funds from 2016 into 2017. You must re-enroll for the 2017 Benefit Period to be eligible for carryover.

How do I get started?

First, estimate what your medical expenses will be in 2016. A full list of eligible expenses is available at www.FSAFEDS.com. You will be surprised at what items are included! You can elect as little as $100 or as much as $2,550 a year.

Once you’ve determined the amount, you can enroll during Open Season at www.FSAFEDS.com. The online enrollment takes about five minutes to complete. If you prefer, you can call FSAFEDS toll-free at 1-877-FSAFEDS (372-3337). Don’t forget to sign up for Paperless Reimbursement with the Service Benefit Plan!

FSAFEDS also offers another helpful feature for employees with families—the Dependent Care FSA. This account allows you to set aside money to pay for your daycare expenses for young children or aging parents.

How easy is FSAFEDS?

It’s very easy; anyone can do it! Enrolling, submitting claims and getting reimbursed is simple, and you can keep track of your account online 24/7—whenever it’s convenient for you. The Service Benefit Plan and FSAFEDS have also partnered to offer a paperless claim option called Paperless Reimbursement. In most cases, you have no paperwork to fill out. You pay the copayment for a prescription, for example, and the Service Benefit Plan sends FSAFEDS a claim for your cost electronically. FSAFEDS processes the claim and sends your reimbursement directly to your bank account.

This article is provided by FSAFEDS and is for informational purposes only. It is not a benefit under the Service Benefit Plan, nor is it an endorsement of FSAFEDS and the services it offers.
WE’RE HERE FOR YOU

Additional Resources

Don’t let your questions go unanswered this Open Season. Here’s where you can go to learn more.

Learn what’s new with the Service Benefit Plan at www.fepblue.org/whatsnew.

Here you’ll find the information you need on the changes we’re making for 2016. You’ll be able to access our 2016 Blue Cross and Blue Shield Service Benefit Plan brochure as well as additional benefit materials. You’ll also learn about other features and services that we offer.

Find out more about the coverage choices available to you at askblue.fepblue.org.

If you’re new to our Program or if you’re currently a member and want to see if you’re in the right coverage option—you can use AskBlue for Federal Employees to help you choose the correct coverage and enrollment type for your family. AskBlue will ask you a series of questions to learn more about your healthcare needs. Once it understands those needs, the tool will give you advice to help you choose the right coverage for you and your family.

Learn more about our health and wellness programs at www.fepblue.org/healthwellness.

We want you to live your life well. That’s why we offer a wide range of health and wellness programs. Find out more about the programs we offer you on our website.

Find a doctor at www.fepblue.org/provider.

We have a large network of Preferred providers. To find a provider in your area, use our provider directory on our website. You can also download the National Doctor and Hospital Finder app to find Preferred providers on the go. Download the provider app on the App Store or Google Play Store today.

Our Open Season Information Center is available to answer your questions about our benefits and coverage options. The Center opens on November 2, 2015.

Call us Monday through Friday from 8 a.m. to 8 p.m. at 1-800-411-BLUE (2583) to speak to a representative.
## 2016 Rate Information

### Standard Option Rates – Your Share

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### Basic Option Rates – Your Share

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These rates do not apply to all Enrollees. If you are in a special enrollment category, please contact the agency or Tribal Employer which maintains your health benefits enrollment.

Visit [www.fepblue.org](http://www.fepblue.org) today.

Discover everything Blue Cross and Blue Shield has to offer.

24/7 Nurse Line 1-888-258-3432

Retail Pharmacy 1-800-624-5060

Mail Service Pharmacy 1-800-262-7890

Overseas Assistance 1-800-699-4337 (U.S., Puerto Rico, or the U.S. Virgin Islands) 1-804-673-1678 (Outside the U.S.)

This is a summary of the features of the 2016 Blue Cross and Blue Shield Service Benefit Plan. Before making a final decision, please read the Plan’s Federal brochure (RI 71-005). All benefits are subject to the definitions, limitations and exclusions set forth in the Federal brochure.